KENTUCKY BOARD OF PHARMACY
23 Millcreek Park
Frankfort, Kentucky 40601-9230
502-573-1580

Permit No._____
Date Issued_____
(For Office Use Only)

Application For Out-of-State Special-Medicinal Gas Pharmacy Permit

Please type. Make check or money order payable to Kentucky State Treasurer. *Mail to: Kentucky Board of Pharmacy,23 Millcreek Park, Frankfort, Kentucky 40601-9230.* ***All applicable entries must be completed. Incomplete applications will be returned.*** *Each permit expires June 30 following the date of issuance.*

1. Name of Pharmacy _____

Physical Address of Pharmacy _____
(Street and Number)

City _____ State _____ Zip _____

Mailing Address of Pharmacy _____
(Street and Number)

City _____ State _____ Zip _____

Phone Number _____ Toll-Free Number _____

Check and complete one of the following and attach proper fee:

☐ New Pharmacy $100.00

Proposed date of Opening _____

(Filed with Board 30 days in advance of Opening)

Current Permit No. _____ Expiration Date _____
(In State where presently located)

☐ Renewal $100.00

(Late Renewal Fee after July 31 . . . $175)

Current Kentucky Permit No. _____

DEA Registration No. _____ Expiration Date _____

Date of Last DEA Schedule II, III, IV and V Inventory _____

(Renewal may be denied if not within last two years)

☐ Change of Ownership $75.00

Date of Proposed Acquisition _____

Name of Previous Owner(s) _____

(Confirmation statement of previous owner must be attached)

☐ Change of Address/Location $75.00

Date of Proposed Relocation _____

Previous Address _____

2. Ownership:

☐ Sole Proprietor ☐ Partnership ☐ Unincorporated Business ☐ Incorporated Business

Name and title for each owner/officer, including professional designation *(e.g. Pres. John Jones, PharmD)*

_____

_____

3. Consultant Pharmacist:

Name	State License No.
_____	_____
_____	_____

Kentucky Pharmacy Regulation 201 KAR 2:205 requires Consultant Pharmacist to notify the Board within fourteen (14) working days of all pharmacist personnel changes.

4. Schedule of Hours:

Monday _____ AM to _____ PM Friday . . _____ AM to _____ PM

Tuesday _____ AM to _____ PM Saturday . _____ AM to _____ PM

Wednesday _____ AM to _____ PM Sunday . . _____ AM to _____ PM

Thursday _____ AM to _____ PM

**Consultant Pharmacist must notify the Board within thirty (30) days of any changes in scheduled hours.

6. Name and address of any hospital, nursing home or home health agency employees of this pharmacy who serve as consultant or part-time pharmacists:

_____

_____

The Board may refuse to issue or renew a permit, or suspend, temporarily suspend, revoke, fine or reasonably restrict any permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit. KRS 315.121.

I hereby certify that the foregoing is true and correct to the best of my knowledge, that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the Regulation of the Kentucky Board of Pharmacy and the Human Resources Cabinet pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all Federal and State laws, and that the pharmacy is currently licensed and in good standing in all states of licensure.

_____ _____

(Signature of Owner) (Signature of Consultant Pharmacist)